IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 3, 2010

Merinda Halladay, Administrator
Belmont Care Center Crestview
3625 Vaughn Street
Pocatello, Idaho 83204

RE: Belmont Care Center Crestview, Provider #13G050

Dear Ms. Halladay:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Belmont Care Center Crestview, on January 26, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 16, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

For

TAYLOR BARKLEY
Health Facility Surveyor
Fire Life Safety & Construction Program

TB/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING 02 B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story residential type building with a type V(000) construction. It has a basement for storage and hot water tanks. It is fully sprinklered with quick response sprinklers, a complete fire alarm /smoke detection system. The home was built /completed on January 11, 1994. Currently it is licensed for 8 ICF/MR beds. The facility had a census of eight clients on the day of the survey. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, adopted 11 March, 2003. In accordance with 42 CFR, 483.470. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED FEB 12 2010 FACILITY STANDARDS	
K0152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must -	K0152	**POC K0152** **483.470(j)(1)(i)** **Life Safety Code Standard** Belmont will ensure that quarterly fire drills are completed and documented. The fire drills will be documented on the Care Tracker Kiosks. To ensure that Belmont is current on their fire drills, a drill will be run on each shift each month.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: CeholLowary — TITLE: Program Director — (X6) DATE: 2/11/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0152	Continued From page 1 (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. This Standard is not met as evidenced by: Based on record review it was determined that the facility failed to hold evacuation drills at least quarterly on each shift. The facility had a census of eight clients on the day of the survey. Findings include: During record review on January 26, 2010 at 9:35 AM, revealed that the facility did not have any documentation for having held a third shift drill during the third quarter and a first shift drill during the fourth quarter of the previous twelve months. Findings were witnessed and noted by Surveyor and the facility Administrator. This deficiency affected all clients and staff present on the day of the survey.	K0152	**Person Responsible:** Maintenance Supervisor, Home Supervisor, Program Director and Administrator **Monitor:** The Maintenance supervisor and home supervisors will run the fire drills monthly. They will complete the drills on the Care Tracker Kiosks. Reports will be pulled monthly and checked by the Administrator and/or Program Director to ensure the drills were run. In addition, a monthly schedule will be given to the Home Supervisor and Maintenance Supervisor with the time frame the drills should be run	3/26/10

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M 000	16.03.11 Inital Comments The facility is a single story residential type building with a type V(000) construction. It has a basement for storage and hot water tanks. It is fully sprinklered with quick response sprinklers, a complete fire alarm /smoke detection system. The home was built /completed on January 11, 1994. Currently it is licensed for 8 ICF/MR beds. The facility had a census of eight clients on the day of the survey. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010. The facility was surveyed under the LIFE SAFETY CODE, 1976 Edition, " Lodging and Rooming Houses " contained in Chapter 11, " Lodging and Rooming House Occupancies " and applicable provisions of Chapters 01 through 07, Chapter 17 and Appendices A and B of the Life Safety Code, Impractical Evacuation Capability in accordance with IDAPA 16.03.11. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000	RECEIVED FEB 12 2010 FACILITY STANDARDS	
MM327	16.03.11.110.02(h) Emergency Electrical Service Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system. This Rule is not met as evidenced by: Based on observation, it was determined that the facility had not ensured that all emergency electrical lighting was maintained in working order. The facility had a census of eight clients on the day of the survey.	MM327	**POC MM327** **16.03.11.110.02(h)** **Emergency Electrical Service** All emergency lighting units in the hallways, stairwells, and entrances will be inspected and repaired by Fire Services of America. Bi-monthly facility inspections and testing of the lights will be completed. At least one of these inspections will be documented and discussed in the monthly safety meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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MM327	Continued From Page 1 The findings include: 1. Observation on January 26, 2010 at 10:17 AM, disclosed that the emergency lighting unit in the Office was not functioning upon pressing of the test button. Findings were witnessed and noted by Surveyor and facility Administrator. This deficiency affected no clients and one staff in one of one smoke compartments. 2. Observation on January 26, 2010 at 10:19 AM, disclosed that the emergency lighting unit by the front door was not functioning upon pressing of the test button. Findings were witnessed and noted by Surveyor and facility Administrator. This deficiency affected all clients and staff present on the day of the survey.	MM327	**Person Responsible:** Maintenance Supervisor, Home Supervisor, and Administrator **Monitor:** Home Supervisors will complete bi-monthly Fire Life Safety checklist of the facility to ensure the emergency lighting is functioning properly. Monthly, the Fire Life Safety checklists will be discussed in Safety Meetings to ensure compliance with all rules and regulations. Quarterly, the Administrator or Program Director will complete environmental audits with maintenance and the home supervisor.	2/12/10
MM335	16.03.11.110.04(a) Diagram of Building A diagram of the building showing emergency protection equipment, evacuation routes, and exits must be conspicuously posted throughout the facility. An outline of emergency instructions must be posted with the diagram. This Rule is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that a diagram displaying the location of emergency equipment and evacuation routes were posted in the facility. The facility had a census of eight clients on the day of the survey. Findings include: During the facility tour on January 26, 2010 at 10:27 AM revealed that the facility did not have a plan posted. Observations were witnessed and noted by both Surveyor and facility Administrator.	MM335	**POC MM 335** **16.03.11.110.04(a)** **Diagram of Building** Evacuation routes and instructions will be posted in the facility to ensure everyone is aware of the proper procedures. **Person Responsible:** Maintenance, Home Supervisor, and Administrator **Monitor:** Home Supervisors will ensure the diagrams and instructions remain posted. Monthly, the Fire life Safety checklists will be discussed in Safety Meetings to ensure compliance with all rules and regulations. Quarterly, the Administrator or Program Director will complete environmental audits with the maintenance and the home supervisor.	3/26/10

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MM335	Continued From Page 2 This deficiency affected all clients and staff present on the day of the survey.	MM335		